

County of San Diego
Low Income Health Program (LIHP)

BILLING AUTHORIZATION FORM

LIHP Enrollee Interpreter Billing Form – language line interpreter services

Instructions:

CLINICS: Please complete the following form after using a language line interpreter service. This will verify that these services have been provided to a LIHP enrollee for the purpose of invoice payment. This form should be faxed back to the County at 858-492-2265, Attn: Emmie Razon or mailed to the County at: Health Care Policy Administration, Attn: Emmie Razon, 8840 Complex Drive, Ste. 255, San Diego, CA 92123.

Please provide all of the following information:

Client Information:

Interpreter services have been provided for the following LIHP enrollee:

Client Name: _____ Date of Birth: _____
LIHP Enrollee #: _____ Eligibility Dates: _____
Language Requested: _____ Nature of Appointment: _____

Service Information:

Name of Interpreter Service: _____
Date of Service: _____
Time of Service: _____

Requester Information:

Name of Clinic: _____
Phone number: _____
Address: _____

Site Contact:

Name: _____
Phone Number (if different): _____